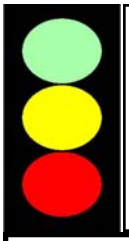
ASTHMA ACTION PLAN FOR PRESCHOOL CHILDREN YEAR 20___ - 20___



Name _____ **DOB**_____

Parent/Guardian _____

Ph (Home) _____ **Ph (Cell)**_____

Doctor **Ph**

CATEGORY OF SEVERITY ☐ MILD ☐ MODERATE ☐ SEVERE ☐ EXERCISE-INDUCED ASTHMA

GO

Green Zone

Child is feeling well

- Breathing is good
- No cough or wheeze
- Sleeps through the night
- Can play

Use Controller Medicines at Home Every Day

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CAUTION

Yellow Zone

Child is not feeling well

- COUGHING day or night
- Wheezing–hard or noisy breathing
- Vomiting after coughing

Other symptoms

- Trouble breathing
- Trouble eating
- Cranky and tired

Other Signs

- Change in sleep pattern
- Not playing as usual
- Reaction to asthma trigger

Rescue Medicine

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN
Rescue medicine: _____ ☐ Nebulizer ☐ Mask ☐ Spacer ☐ Inhaler	☐ Give a nebulizer treatment ☐ Give ____ puffs of metered dose inhaler	Stay with child and keep child quiet for 15 minutes Encourage child to drink fluids If symptoms not improved, may repeat rescue medicine ONCE Call parent to report child had breathing problem **IF STILL HAVING TROUBLE, FOLLOW RED ZONE**

NOTE: Parent should contact the doctor if child needs rescue med >2 times/wk to see if a medication change is necessary.

STOP

Red Zone

Child is very sick
Danger-Get Help!

- Medicine is not helping
- Constant cough
- Working hard to breathe
- Trouble walking or talking
- Child looks very sick

Get Help from a Doctor

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN
Rescue medicine: _____ ☐ Nebulizer ☐ Mask ☐ Spacer ☐ Inhaler	☐ Give a nebulizer treatment ☐ Give_____ puffs of metered dose inhaler	Give rescue medicine NOW Watch child closely Repeat rescue medicine in 15 minutes if still in distress
Call parent. If not better, call doctor. IF IN SEVERE DISTRESS, CALL 911.		

Doctor signature: _____ Date_____

I hereby release the local School Board and their agents and employees and the child care providers from any liability that may result from my child taking the prescribed medication. I give permission for my child to receive medications and for health care providers to exchange information regarding the care of my child. I agree to provide rescue medication to be kept at the child care center in case of emergency.

Parent/Guardian: _____ Date_____

WHITE—CHILD CARE PROVIDER YELLOW—PATIENT/PARENT PINK—DOCTOR

ORIGINAL 03/08 REV 06/09

Albemarle Pediatric Asthma Coalition